

Date: \_\_\_\_\_

Section I (Client Information):

NAME \_\_\_\_\_  
Last First Middle

ADDRESS \_\_\_\_\_  
Street City State Zip

PHONE (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
H:Can we use to call/message? Y N W:Can we use to call/message? Y N C:Can we use to call/message/text? Y N

EMAIL ADDRESS \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_  
Can we use for contact & billing? Y N

EMPLOYER \_\_\_\_\_ JOB TITLE \_\_\_\_\_

DEMOGRAPHICS \_\_\_\_\_  
Birthdate |Age |Years of | Marital Status |length of current  
Education (Sng;Mrd;Sep;Div;Wid) relationship

\_\_\_\_\_  
List Ages & Gender of Children

REFERRAL SOURCE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ Relationship: \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Street City State Zip

PHONE (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Work Cell

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Section II (Insurance Information)

Primary Insurance:

NAME OF INSURED \_\_\_\_\_ Relationship \_\_\_\_\_  
(Spouse;parent;etc)

PHONE (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Work

BIRTHDATE OF INSURED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_

MEDICAL INSURANCE CO. \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_  
Street City State Zip

IDENTIFICATION# \_\_\_\_\_

GROUP# \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_ Relationship \_\_\_\_\_  
(Spouse;parent;etc)

PHONE (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Work

BIRTHDATE OF INSURED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_

MEDICAL INSURANCE CO. \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_  
Street City State Zip

IDENTIFICATION# \_\_\_\_\_

GROUP# \_\_\_\_\_

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Section III (Medical History)

List all current medical conditions including allergies and adverse medication reactions.

List past medical conditions.

List all medications you are currently taking including dosages and the dates of the initial prescriptions and most recent refill.

Medication	Dosage	Initial Rx Date	Last Refill Date
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List a history of medications you have taken in the past including dosages and the dates of the initial prescriptions and date of last use.

Medication	Dosage	Initial Rx Date	Last Use Date
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Are you presently under the care of a physician (if yes, list name and address of physician)?

When was your last complete physical exam?

Average number and type of alcoholic beverages consumed per week?

Average number and type of caffeinated beverages consumed per week?

How much and how frequently do you use tobacco?

How much and how frequently do you use non-prescription drugs? (Please list all drugs separately)

Section IV (Treatment History)

Indicate the names, occupations, treatment dates, and the helpfulness of professionals you have consulted for your treatment issues

Name	Occupation	Begin Date	End Date	Helpful?
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Indicate the names, occupations, treatment dates, and helpfulness of mental health professionals you have consulted in your lifetime (include individual, group, couples, and family counseling as well as participation in any drug or alcohol treatment program).

Name	Occupation	Begin Date	End Date	Helpful?
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Section V (Family history of mental health issues and substance use)

A) List any family history of mental health or substance abuse (including alcohol) problems in your family history. List the relationship (e.g., brother, mother, etc..) followed by the problem issue.